EXECUTIVE SUMMARY

PURPOSE:

To evaluate carrier fraud units and identify factors that contribute to and work against successful program integrity operations.

BACKGROUND:

In 1994, Medicare carriers processed over 615 million claims. That same year, carriers received about 118,000 complaints alleging fraud or abuse. The Health Care Financing Administration (HCFA) has charged their contractors with the responsibility of detecting and deterring program fraud, waste and abuse. Both carriers and intermediaries have set up fraud and abuse units as one element of HCFA's overall benefit integrity program. To help defray the cost of investigating complaints, HCFA provided the carriers with nearly $23 million to fund their fraud units.

We obtained information from 37 carrier fraud units. We examined selected case files and obtained documentation relating to program integrity operations. We interviewed 292 employees and visited 6 carrier units to carry out in-person discussions. Based on the information we obtained, we compared carrier performance using the following five criteria:

- Accuracy of complaint disposition
- Case documentation
- Assessing financial damage
- Internal proactive safeguards
- External proactive safeguards

FINDINGS:

Very few carriers were successful in meeting all of our outcome criteria.

Only two carriers consistently ranked high when we analyzed fraud unit performance using the five criteria mentioned above. We found that few carrier fraud units follow case development procedures. Overpayment information is often inaccurate and information concerning frequency and nature of past problems with providers is often missing. Despite claims of being proactive in their approach to combating fraud and abuse, only 14 carriers could provide evidence that they took steps to correct vulnerabilities they identified in their claims processing systems, policies and procedures.

The most effective program integrity efforts are found in corporations that accord a high priority and adequate management attention to the fraud units.

Resources and Organization. Strategic organizational placement of most, if not all, postpayment functions within the jurisdiction of the fraud units appears to be key to

better performance. Effective fraud units are part of a corporate culture that supports them in hiring and keeping highly motivated and qualified persons. They invested more in competitive salaries, technology and ongoing staff training.

Staffing. Successful fraud units integrate persons with law enforcement backgrounds with personnel who have knowledge of claims processes and policies. Analysts, auditors and statisticians are hired to meet special needs. No one discipline dominates the successful fraud unit. Less successful fraud units employed staff with backgrounds primarily from a single prepayment discipline such as provider relations or claims processing.

Training. Staff at better units receive ongoing training from internal and external sources. In other fraud units, at least 2 out of every 3 people have had no HCFA, Office of Inspector General or other outside training on fraud and abuse since HCFA began funding fraud units in the fall of 1992.

RECOMMENDATIONS:

Concerns regarding the effectiveness of Medicare carrier fraud units are similar to those discussed in our report entitled ***"Surveillance and Utilization Review Subsystems' Case Referrals to Medicaid Fraud Control Units," OEI-07-95-00030.*** As a result, we believe that a concerted effort addressing both Medicare and Medicaid fraud units is called for. We are proposing a uniform team approach. We recommend that HCFA, in consultation with the Office of Inspector General should:

Convene a Medicare and Medicaid fraud and abuse task force to plan and implement improvements in fraud unit operations. This would include:

- Clarifying goals and objectives for program integrity efforts.
- Establishing guidelines for developing suspected fraud cases.
- Developing a universal protocol for appropriately referring fraud and abuse cases.
- Coordinating data systems to ensure that data are reliable and consistent across all entities in the fraud and abuse fighting network.
- Developing a training program designed to educate program integrity personnel on procedures, case referrals and best practices.

Continue to provide support and technical assistance to carriers so they can emulate those carriers operating successful programs. This can include:

- Encouraging carrier commitments that result in increased resources to combat fraud and abuse such as investments in technology and people.

- Suggesting ways of organizing a successful program integrity effort.

- Limiting the role of medical review units in program integrity to those cases involving issues of abuse, policy, coverage and medical necessity.

- Rewarding carriers for identifying policy, procedure and systems vulnerabilities and implementing corrective safeguards.

- Separating the budget for postpayment activity from the budget for claims processing and other front-end operations such as provider enrollment and provider relations.

AGENCY COMMENTS

We appreciate all the positive steps that HCFA has taken thus far to safeguard the Medicare program and we recognize the accomplishments of the Program Integrity Group. We are pleased that HCFA has concurred with our recommendations and we look forward to working with HCFA in their implementation.

We believe that the best approach would be a collaborative one involving HCFA and OIG, with consultation from high performing State Surveillance and Utilization Review Subsystem Units (S/URS) and carriers. We suggest that this effort focus on:

- Developing and implementing model practices.

- Revising current contractor performance measures that reward carriers for overpayment recovery but not for fraud and abuse referrals or efforts to improve claims processing safeguards.

- Identifying the most effective practices which carrier and State personnel use to eliminate claims processing vulnerabilities that enable providers to defraud health programs.

We believe that achieving the goals both HCFA and the OIG have established for improving program integrity functions at the carriers and in the States can best be accomplished by these kinds of collaborative efforts. We look forward to working with HCFA to bring about further measurable change.